SECTION 4. Section 18H½ of chapter 6A of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in line 4, the words "December 31, 2007" and inserting in place thereof the following words:- June 30, 2008

SECTION 5. Chapter 15A of the General Laws is hereby amended by inserting after section 22 the following section:-

Section 22A. (a) For purposes of this section, the following words shall have the following meanings:-

"Board", the Board of Trustees of the Roxbury Community College.

"Center", the Reggie Lewis Track and Athletic Center established pursuant to subsection (b).

"College", the Roxbury Community College.

"Use for nonpublic purposes", shall include, but not be limited to, the leasing or renting of the building for commercial entertainment activity.

"Use for public purposes", shall include, but not be limited to, use by Massachusetts public high school track programs, members of the abutting residential community or by members of the community at large and students, faculty, staff, and alumni at Roxbury Community College.

(b) There is hereby established the Reggie Lewis Track and Athletic Center at Roxbury Community College. The center shall be a building containing a Massachusetts state track facility which shall be maintained at the college for public purposes. In the event the facility is not in use for public purposes, the board may permit use for nonpublic purposes for a rental amount to be determined by said board.

(c) The board shall be responsible for the management and operation of the center including, but not limited to, the following:-

(i) establishing user fees;

(ii) entering into agreements with the Massachusetts State Track Coaches Association, with other public groups and, pursuant to the provisions of this section, with nonpublic groups interested in leasing or renting the center for commercial entertainment activity;

(iii) establishing rules and regulations for the use of the center by Massachusetts public high school track programs, by members of the abutting residential neighborhoods and members of the community at large, by students, faculty, and staff and alumni of Roxbury Community College, and, pursuant to the provisions of this section, by

nonpublic groups interested in leasing or renting the center for commercial entertainment activity;

(iv) deciding the priority of uses and schedule of the center with input from an advisory committee; and

(v) entering into agreements with vendors to provide concession stand services and other agreements as deemed necessary by the board for the maintenance and operation of the center.

(d) The center shall be made available without charge for use by Massachusetts public high school track programs and Roxbury Community College. The center shall be made available on a user fee basis for members of the public. The center shall be made available at market rate, as determined by the board, for nonpublic or commercial entertainment purposes so long as the center is not being used for public purposes.

(e) The annual operating expenses of the center shall be separate and distinct from appropriations within the general appropriations act for the college, shall use a separate item of appropriation and shall be audited biennially by the state auditor.

SECTION 6. Chapter 22 of the General Laws is hereby amended by striking out section 12, as so appearing, and inserting in place thereof the following section:-

Section 12. There shall be in the department a commission, to be known as the state boxing commission, which shall consist of 3 members to be appointed by the governor with the advice and consent of the council, for terms of 3 years each. The governor, with the advice and consent of the council, shall from time to time designate 1 member of said commission as chairman. The members shall receive their traveling expenses necessarily incurred in the performance of their duties, and the commission shall be allowed such sums for clerical assistance as the governor and council may approve. The secretary of the department shall act as the secretary of the commission and shall keep full and true records of all its proceedings. The commission may deputize 1 or more persons to represent the commission, and to be present at any match or exhibition authorized to be held under sections 32 to 51 of chapter 147. Such persons may receive such compensation for their traveling expenses necessarily incurred in the discharge of their duties.

SECTION 7. Section 2EEE of chapter 29 of the General Laws is hereby repealed.

SECTION 8. Chapter 32A of the General Laws, as so appearing, is hereby amended by adding the following section:-

Section 24. (a) There is hereby established and set up on the books of the commonwealth a trust fund to be known as the State Retiree Benefits Trust Fund, hereinafter in this section referred to as the trust fund. The pension reserves investment management board established pursuant to section 23 of chapter 32, in this section called

the board, shall be the trustee of and shall administer the trust fund. For the purposes of this section the secretary of the executive office of administration and finance, or his designee, and the executive director of the group insurance commission established pursuant to section 3 of chapter 32A, or his designee, shall be members of the board. The provisions of section 23 of chapter 32 shall apply to the management of the trust fund. The trust fund shall be an expendable trust not subject to appropriation.

(b) The purpose of said trust fund shall be for depositing, investing and disbursing amounts set aside solely to meet liabilities of the state retirement system for health care and other non-pension benefits for retired members of the system. There shall be credited to the trust fund any revenue from appropriations or other monies authorized by the general court and specifically designated to be credited to the trust fund, and any gifts, grants, private contributions, investment income earned on the trust fund's assets and all other sources. Money remaining in the fund at the end of a fiscal year shall not revert to the General Fund.

(c) Upon request of the group insurance commission established pursuant to section 3 of chapter 32A, the board may expend amounts in the trust fund, without further appropriation, to pay the costs of health care and other non-pension benefits for retired members of the state retirement system; provided, however, that said group insurance commission shall remain responsible for administering the payment of, and determining the terms, conditions, schedule of benefits, carriers and eligibility for, health care and other non-pension benefits for retired members of the state retirement system.

(d) Upon authorization by the board, any other retirement system of the commonwealth may participate in the trust fund using the same procedures required for participation in the pension reserves investment trust fund pursuant to section 22 of chapter 32.

(e) The trust fund shall be revocable only when all such health care and other non-pension benefits, current and future, payable pursuant to this chapter have been paid or defeased.

SECTION 9. Section 9A of chapter 118E of the General Laws, as amended by section 17 of chapter 324 of the acts of 2006, is hereby further amended by adding the following subsection:-

(16) The division shall enroll MassHealth members in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance, and if federal approval will be obtained to ensure federal reimbursement for premium assistance for that insurance.

SECTION 10. Chapter 118E of the General Laws, as amended by section 28 of chapter 58 of the acts of 2006, is hereby further amended by striking out section 23 and inserting in place thereof the following section:-

Section 23. As used in this section, health care insurer, health insurer and health insurance shall include, but not be limited to, any health insurance company, health maintenance organization, group or non-group health plan, self-insured plan, service benefit plan, managed care organization, pharmacy benefit manager, or other public or private third party that is, by statute, contract, agreement, or arrangement legally responsible for payment of a claim for health care benefits.

Notwithstanding any general or special law, rule or regulation to the contrary, the division shall be subrogated to the rights of any recipient of medical assistance pursuant to this chapter and may take any and all actions available to such recipient to secure benefits under any policy issued by any health care insurer that is or may be liable to pay for health care benefits obtained by a recipient of medical assistance to the extent of any health care benefits provided by the division on behalf of said recipient or said recipient's dependents. A health care insurer shall reimburse the division for any health care benefits provided by the division on behalf of a recipient of medical assistance, and shall not reduce the amount of the total reimbursement by any division payment, provided that any part of the total that is a reimbursement for a division payment shall not exceed the amount actually paid by the division.

No health care insurer shall require written authorization from the recipient before honoring the division's rights pursuant to this section. A health care insurer shall respond to any inquiry by the division about a claim for payment for any health care benefits and may not deny any claim for payment for any health care benefits solely on the basis of the date of submission of the claim, the type of format for the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if the claim is submitted by the division within a 3-year period beginning on the date on which the service was furnished, and if any action by the division to enforce its rights with respect to a claim is filed within 6 years after the submission of the claim to the health insurer.

A recipient of medical assistance or any person legally obligated to support and have actual or legal custody of a recipient of medical assistance shall inform the division of any health insurance available to such recipient upon initial application and redetermination for eligibility for assistance and shall make known the nature and extent of any health insurance coverage to any person or institution that provides medical benefits to the recipient or his or her dependent.

A health care insurer shall not take into account that an individual is eligible for or is receiving benefits from the division when enrolling an individual or issuing a policy or agreement covering the individual, or administering or renewing a policy or agreement, or when making any payment for health care benefits to the individual or on behalf of the individual; nor shall any policy or agreement issued, administered, or renewed by a health care insurer contain any provision denying or reducing health care benefits to an individual who is eligible for or is receiving benefits from the division.

A provider of medical assistance pursuant to this chapter shall determine whether

any recipient for whom it provides medical care or services which are or may be eligible for reimbursement pursuant to this chapter is a subscriber or beneficiary of a health insurance plan. The division shall be the payor of last resort and a provider shall request payment for medical care or services it provides from a health insurer which is or may be liable for the medical care or services so provided prior to requesting payment from the division.

Payment by the division pursuant to the medical assistance programs established pursuant to this chapter shall constitute payment in full; subsequent to any such payment a provider may not recover from any health insurer an amount greater than the amount so paid by the division for any service for which the division is to be the payor of last resort.

Notwithstanding any general or special law or rule or regulation to the contrary, all holders of health insurance information, including, but not limited to, health insurers doing business in the commonwealth, all private and public entities who employ individuals in the commonwealth, and all agencies of the commonwealth, shall provide sufficient information to the division, or in the case of those agencies, shall make other arrangements mutually satisfactory to both agencies, to enable the division: (a) to identify whether any of the following persons are or could be beneficiaries under any policy of insurance in the commonwealth: (i) persons applying for or receiving medical assistance or benefits pursuant to this chapter or health services through an agency under the executive office of health and human services, and (ii) persons for whom hospitals and community health centers claim reimbursement payments from the Health Safety Net Fund, established pursuant to section 35 of chapter 118G; and (b) to determine the nature of the coverage that is or was provided, including cost, scope, terms, periods of coverage, and any identifying name, address or number of the policy of insurance. All public and private entities who employ individuals in the commonwealth shall provide, when requested by any employee applying for or receiving benefits provided by the division, written information to the employee describing the availability of health insurance, if any, provided by or through the employer. The failure of an employer to provide an employee with the information shall not be grounds for denial of benefits by the division.

The division may, after notice and opportunity for hearing, garnish the wages, salary, or other employment income of, and shall, with the assistance of the department of revenue pursuant to section 3 of chapter 62D, withhold amounts from state tax refunds to, any person who: (a) is required by court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance pursuant to this chapter; (b) has received payment from a third party for the costs of those services to the child; but (c) has not used the payments to reimburse either the other parent or guardian of the child or the provider of the services, to the extent necessary to reimburse the division for expenditures for those costs.

SECTION 11. Sections 55 to 60, inclusive, of chapter 118E of the General Laws, inserted by section 30 of said chapter 58 of the acts of 2006, are hereby repealed.

SECTION 12. Section 25 of said chapter 118G of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in lines 24 and 25, the words "Health Care Security Trust Fund established pursuant to chapter 29D" and inserting in place thereof the following words:- General Fund.

SECTION 13. Said chapter 118G of the General Laws, as most recently amended by section 1 of chapter 268 of the acts of 2006, is hereby further amended by adding at the end thereof the following sections:-

Section 34. As used in section 34 through section 39, inclusive, the following words shall, unless the context clearly requires otherwise, have the following meanings:—

"Acute hospital", the teaching hospital of the University of Massachusetts Medical School and any hospital licensed under section 51 of chapter 111 and which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public health.

"Allowable reimbursement", payment to acute hospitals and community health centers for health services provided to uninsured patients of the commonwealth under section 60 and any further regulations promulgated by the office.

“Ambulatory surgical center”, a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the requirements of the federal Health Care Financing Administration for participation in the Medicare program.

“Ambulatory surgical center services”, services described for purposes of the Medicare program under 42 U.S.C. 1395k(a)(2)(F)(I). These services include facility services only and do not include surgical procedures.

“Bad debt”, an account receivable based on services furnished to a patient which: (i) is regarded as uncollectible, following reasonable collection efforts consistent with regulations of the office, which regulations shall allow third party payers to negotiate with hospitals to collect the bad debts of its enrollees; (ii) is charged as a credit loss; (iii) is not the obligation of a governmental unit or the federal government or any agency thereof; and (iv) is not a reimbursable health care service.

“Community health center”, a health center operating in conformance with the requirements of Section 330 of United States Public Law 95-626, including all community health centers which file cost reports as requested by the division of health care finance and policy.

“Critical access services”, those health services which are generally provided only by acute hospitals, as further defined in regulations promulgated by the division.

“Director”, the director of the health safety net office.

"DRG", a patient classification scheme known as diagnosis related grouping, which provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost incurred by the hospital.

"Emergency bad debt", bad debt resulting from emergency services provided by an acute hospital to an uninsured or underinsured patient or other individual who has an emergency medical condition that is regarded as uncollectible, following reasonable collection efforts consistent with regulations of the office.

"Emergency medical condition", a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. 1295dd(e)(1)(B).

"Emergency services", medically necessary health care services provided to an individual with an emergency medical condition.

"Financial requirements", a hospital's requirement for revenue which shall include, but not be limited to, reasonable operating, capital and working capital costs, and the reasonable costs associated with changes in medical practice and technology.

"Fund", the Health Safety Net Trust Fund established pursuant to section 36.

"Fund fiscal year", the 12-month period starting in October and ending in September.

"Gross patient service revenue", the total dollar amount of a hospital's charges for services rendered in a fiscal year.

"Health services", medically necessary inpatient and outpatient services as mandated under Title XIX of the federal Social Security Act. Health services shall not include: (1) nonmedical services, such as social, educational and vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and consultations; (5) court testimony; (6) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-surgery hormone therapy; and (7) the provision of whole blood, but the administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

"Office", the health safety net office established pursuant to section 35.

"Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge payors to acute hospitals for health services and ambulatory surgical centers for

ambulatory surgical center services; provided, however, that "payments subject to surcharge" shall not include: (i) payments, settlements and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies; (ii) payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in policies issued under chapter 176K or similar policies issued on a group basis; and provided further, that "payments subject to surcharge" may exclude amounts established pursuant to regulations promulgated by the division for which the costs and efficiency of billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost effective.

"Pediatric hospital", an acute care hospital which limits services primarily to children and which qualifies as exempt from the Medicare Prospective Payment system regulations.

"Pediatric specialty unit", a pediatric unit of an acute care hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20. In calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds, and the total of all licensed hospital beds shall include the total of all licensed acute care hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

"Private sector charges", gross patient service revenue attributable to all patients less gross patient service revenue attributable to Titles XVIII and XIX, other public-aided patients, reimbursable health services and bad debt.

"Reimbursable health services", health services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or part, under applicable regulations of the office; provided that the health services are emergency, urgent and critical access services provided by acute hospitals or services provided by community health centers; and provided further, that such services shall not be eligible for reimbursement by any other public or private third-party payer.

"Resident", a person living in the commonwealth, as defined by the office by regulation; provided, however, that such regulation shall not define as a resident a person who moved into the commonwealth for the sole purpose of securing health insurance under this chapter. Confinement of a person in a nursing home, hospital or other medical institution shall not in and of itself, suffice to qualify such person as a resident.

"Surcharge payor", an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals and ambulatory surgical center services provided by ambulatory surgical centers, as defined in this section; provided, however, that the term "surcharge payor" shall not include Title XVIII and Title XIX programs and their beneficiaries or recipients, other governmental programs of public assistance and their beneficiaries or recipients and the workers' compensation program established pursuant to chapter 152.

“Underinsured patient”, a patient whose health insurance plan or self-insurance health plan does not pay, in whole or in part, for health services that are eligible for reimbursement from the health safety net trust fund, provided that such patient meets income eligibility standards set by the office.

“Uninsured patient”, a patient who is a resident of the commonwealth, who is not covered by a health insurance plan or a self-insurance health plan and who is not eligible for a medical assistance program.

Section 35. (a) There shall be established within the division of health care finance and policy a health safety net office which shall be under the supervision and control of a director. The director shall be appointed by the commissioner, in consultation with the secretary of health and human services and the Medicaid director, and shall be a person of skill and experience in the field of health care finance and administration. The director shall be the executive and administrative head of the office and shall be responsible for administering and enforcing the provisions of law relative to the office and to each administrative unit thereof. The director shall receive such salary as may be determined by law, and shall devote his full time to the duties of his office. In the case of an absence or vacancy in the office of the director, or in the case of disability as determined by the commissioner, the commissioner may designate an acting director to serve as director until the vacancy is filled or the absence or disability ceases. The acting director shall have all the powers and duties of the director and shall have similar qualifications as the director.

(b) The office shall have the following powers and duties:-

(i) to administer the Health Safety Net Trust Fund, established pursuant to section 36, and to require payments to the fund consistent with acute hospitals' and surcharge payors' liability to the fund, as determined pursuant to sections 37 and 38, and any further regulations promulgated by the office;

(ii) to set, after consultation with the office of Medicaid, reimbursement rates for payments from the fund to acute hospitals and community health centers for reimbursable health services provided to uninsured and underinsured patients and to disburse monies from the fund consistent with such rates; provided that the office shall implement a fee-for-service reimbursement system for acute hospitals;

(iii) to promulgate regulations further defining: (a) eligibility criteria for reimbursable health services; (b) the scope of health services that are eligible for reimbursement by the Health Safety Net Trust Fund; (c) standards for medical hardship; and (d) standards for reasonable efforts to collect payments for the costs of emergency care. The office shall implement procedures for verification of eligibility using the eligibility system of the office of Medicaid and other appropriate sources to determine the eligibility of uninsured and underinsured patients for reimbursable health services and shall establish other procedures to ensure that payments from the fund are made for health services for which there is no other public or private third party payer, including

disallowance of payments to acute hospitals and community health centers for free care provided to individuals if reimbursement is available from other public or private sources;

(iv) to develop programs and guidelines to encourage maximum enrollment of uninsured individuals who receive health services reimbursed by the fund into health care plans and programs of health insurance offered by public and private sources and to promote the delivery of care in the most appropriate setting, provided that the programs and guidelines are developed in consultation with the commonwealth health insurance connector, established pursuant to chapter 176Q. These programs shall not deny payments from the fund because services should have been provided in a more appropriate setting if the hospital was required to provided the services pursuant to 42 U.S.C. 1395 (dd);

(v) to conduct a utilization review program designed to monitor the appropriateness of services for which payments were made by the fund and to promote the delivery of care in the most appropriate setting; and to administer demonstration programs that reduce Health Safety Net Trust Fund liability to acute hospitals, including a demonstration program to enable disease management for patients with chronic diseases, substance abuse and psychiatric disorders through enrollment of patients in community health centers and community mental health centers and through coordination between these centers and acute hospitals, provided, that the office shall report the results of these reviews annually to the joint committee on health care financing and the house and senate committees on ways and means;

(vi) to administer, in consultation with the office of Medicaid, the Essential Community Provider Trust Fund, established pursuant to section 2PPP of chapter 29, and to make expenditures from that fund without further appropriation for the purpose of improving and enhancing the ability of acute hospitals and community health centers to serve populations in need more efficiently and effectively, including, but not limited to, the ability to provide community-based care, clinical support, care coordination services, disease management services, primary care services, and pharmacy management services through a grant program. The office shall consider applications from acute hospitals and community health centers in awarding the grants. The criteria for selection shall include, but not be limited to, the following: (a) the financial performance of the provider as determined, in the case of applications from acute hospitals, quarterly by the division of health care finance and policy and by consulting other appropriate measurements of financial performance; (b) the percentage of patients with mental or substance abuse disorders served by a provider; (c) the numbers of patients served by a provider who are chronically ill, elderly, or disabled; (d) the payer mix of the provider, with preference given to acute hospitals where a minimum of 63 per cent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act or other governmental payors, including reimbursements from the Health Safety Net Trust Fund; (e) the percentage of total annual operating revenue that funding received in fiscal years 2005 and 2006 from the Distressed Provider Expendable Trust

Fund comprised for the provider; and (f) the cultural and linguistic challenges presented by the populations served by the provider.

(vii) to enter into agreements or transactions with any federal, state or municipal agency or other public institution or with a private individual, partnership, firm, corporation, association or other entity, and to make contracts and execute all instruments necessary or convenient for the carrying on of its business;

(viii) to secure payment, without imposing undue hardship upon any individual, for unpaid bills owed to acute hospitals by individuals for health services that are ineligible for reimbursement from the Health Safety Net Trust Fund which have been accounted for as bad debt by the hospital and which are voluntarily referred by a hospital to the department for collection; provided, however that such unpaid charges shall be considered debts owed to the commonwealth and all payments received shall be credited to the fund; and provided, further, that all actions to secure such payments shall be conducted in compliance with a protocol previously submitted by the office to the joint committee on health care financing;

(ix) to require hospitals and community health centers to submit to the office data that it reasonably considers necessary;

(x) to make, amend and repeal rules and regulations to effectuate the efficient use of monies from the Health Safety Net Trust Fund; provided, however, that the regulations shall be promulgated only after notice and hearing and only upon consultation with the board of the commonwealth health insurance connector, the secretary of health and human services, the director of the office of Medicaid and representatives of the Massachusetts Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts Safety Net Hospitals and the Massachusetts League of Community Health Centers; and

(xi) to provide an annual report at the close of each fund fiscal year, in consultation with the office of Medicaid, to the joint committee on health care financing and the house and senate committees on ways and means, evaluating the processes used to determine eligibility for reimbursable health services, including the Virtual Gateway, so called. Said report shall include, but not be limited to, the following: (a) an analysis of the effectiveness of these processes in enforcing eligibility requirements for publicly-funded health programs and in enrolling uninsured residents into programs of health insurance offered by public and private sources; (b) an assessment of the impact of these processes on the level of reimbursable health services by providers; and (c) recommendations for ongoing improvements that will enhance the performance of eligibility determination systems and reduce hospital administrative costs.

Section 36. (a) There shall be established and set up on the books of the commonwealth a fund to be known as the Health Safety Net Trust Fund, in this section and in sections 37 to 39, inclusive, called the fund, which shall be administered by the office. Expenditures from the fund shall not be subject to appropriation unless otherwise

required by law. The purpose of the fund shall be to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of reimbursable health services provided to low-income, uninsured or underinsured residents of the commonwealth. The office shall administer the fund using such methods, policies, procedures, standards and criteria that it deems necessary for the proper and efficient operation of the fund and programs funded by it in a manner designed to distribute the fund resources as equitably as possible.

(b) The fund shall consist of all amounts paid by acute hospitals and surcharge payors pursuant to sections 37 and 38; all appropriations for the purpose of payments to acute hospitals or community health centers for health services provided to uninsured and underinsured residents; any transfers from the Commonwealth Care Trust Fund, established pursuant to section 2OOO of chapter 29; and all property and securities acquired by and through the use of monies belonging to the fund and all interest thereon. Amounts placed in the fund shall, except for amounts transferred to the Commonwealth Care Trust Fund, be expended by the office for payments to hospitals and community health centers for reimbursable health services provided to uninsured and underinsured residents of the commonwealth, consistent with the requirements of this section and section 39 and the regulations promulgated by the office; provided, however, that $6,000,000 shall be expended annually from the fund for demonstration projects that use case management and other methods to reduce the liability of the fund to acute hospitals. Any annual balance remaining in the fund after these payments have been made shall be transferred to the Commonwealth Care Trust Fund. All interest earned on the amounts in the fund shall be deposited or retained in the fund. The director shall from time to time requisition from the fund amounts that he considers necessary to meet the current obligations of the office for the purposes of the fund and estimated obligations for a reasonable future period.

Section 37. (a) An acute hospital's liability to the fund shall equal the product of (1) the ratio of its private sector charges to all acute hospitals' private sector charges; and (2) $160,000,000. Annually, prior to October 1, the office, in consultation with the office of Medicaid, shall establish each acute hospital's liability to the fund using the best data available, as determined by the division, and shall update each acute hospital's liability to the fund as updated information becomes available. The office shall specify by regulation an appropriate mechanism for interim determination and payment of an acute hospital's liability to the fund. An acute hospital's liability to the fund shall in the case of a transfer of ownership be assumed by the successor in interest to the acute hospital.

(b) The office shall establish by regulation an appropriate mechanism for enforcing an acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled payment to the fund. These enforcement mechanisms may include (1) notification to the office of Medicaid requiring an offset of payments on the Title XIX claims of any such acute hospital or any health care provider under common ownership with the acute care hospital or any successor in interest to the acute hospital, and (2) the withholding by the office of Medicaid of the amount of payment owed to the fund, including any interest and late fees, and the transfer of the withheld funds into the fund. If

the office of Medicaid offsets claims payments as ordered by the office, it shall not be considered to be in breach of contract or any other obligation for the payment of non-contracted services, and providers whose payment is offset pursuant to an order of the division shall serve all Title XIX recipients under the contract then in effect with the office of Medicaid, or, in the case of a non-contracting or disproportionate share hospital, under its obligation for providing services to Title XIX recipients pursuant to this chapter. In no event shall the office direct the office of Medicaid to offset claims unless an acute hospital has maintained an outstanding obligation to the fund for a period longer than 45 days and has received proper notice that the division intends to initiate enforcement actions pursuant to regulations promulgated by the office.

Section 38. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge on all payments subject to surcharge as defined in section 1. The surcharge shall be distinct from any other amount paid by a surcharge payor for the services of an acute hospital or ambulatory surgical center. The surcharge amount shall equal the product of (i) the surcharge percentage and (ii) amounts paid for these services by a surcharge payor. The office shall calculate the surcharge percentage by dividing $160,000,000 by the projected annual aggregate payments subject to the surcharge. The office shall determine the surcharge percentage before the start of each fund fiscal year and may redetermine the surcharge percentage before April 1 of each fund fiscal year if the office projects that the initial surcharge established the previous October will produce less than $150,000,000 or more than $170,000,000. Before each succeeding October 1, the office shall redetermine the surcharge percentage incorporating any adjustments from earlier years. In each determination or redetermination of the surcharge percentage, the office shall use the best data available as determined by the division and may consider the effect on projected surcharge payments of any modified or waived enforcement pursuant to subsection (e). The office shall incorporate all adjustments, including, but not limited to, updates or corrections or final settlement amounts, by prospective adjustment rather than by retrospective payments or assessments.

(b) Each acute hospital and ambulatory surgical center shall bill a surcharge payor an amount equal to the surcharge described in subsection (a) as a separate and identifiable amount distinct from any amount paid by a surcharge payor for acute hospital or ambulatory surgical center services. Each surcharge payor shall pay the surcharge amount to the office for deposit in the Health Safety Net Trust Fund on behalf of said acute hospital or ambulatory surgical center. Upon the written request of a surcharge payor, the office may implement another billing or collection method for the surcharge payor; provided, however, that the office has received all information that it requests which is necessary to implement such billing or collection method; and provided further, that the office shall specify by regulation the criteria for reviewing and approving such requests and the elements of such alternative method or methods.

(c) The office shall specify by regulation appropriate mechanisms that provide for determination and payment of a surcharge payor's liability, including requirements for data to be submitted by surcharge payors, acute hospitals and ambulatory surgical centers.

(d) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be assumed by the successor in interest to the surcharge payor.

(e) The office shall establish by regulation an appropriate mechanism for enforcing a surcharge payor's liability to the fund if a surcharge payor does not make a scheduled payment to the fund; provided, however, that the office may, for the purpose of administrative simplicity, establish threshold liability amounts below which enforcement may be modified or waived. Such enforcement mechanism may include assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement mechanism may also include notification to the office of Medicaid requiring an offset of payments on the claims of the surcharge payor, any entity under common ownership or any successor in interest to the surcharge payor, from the office of Medicaid in the amount of payment owed to the fund including any interest and penalties, and to transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as ordered by the office, the office of Medicaid shall be considered not to be in breach of contract or any other obligation for payment of non-contracted services, and a surcharge payor whose payment is offset pursuant to an order of the division shall serve all Title XIX recipients under the contract then in effect with the executive office of health and human services. In no event shall the office direct the office of Medicaid to offset claims unless the surcharge payor has maintained an outstanding liability to the fund for a period longer than 45 days and has received proper notice that the office intends to initiate enforcement actions pursuant to regulations promulgated by the office.

(f) If a surcharge payor fails to file any data, statistics or schedules or other information required pursuant to this chapter or by any regulation promulgated by the office, the office shall provide written notice to the payor. If a surcharge payor fails to provide required information within 2 weeks after the receipt of written notice, or falsifies the same, he shall be subject to a civil penalty of not more than $5,000 for each day on which the violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction. The attorney general shall bring any appropriate action, including injunctive relief, that may be necessary for the enforcement of this chapter.

Section 39. (a) Reimbursements from the fund to hospitals and community health centers for health services provided to uninsured individuals shall be subject to further rules and regulations promulgated by the office and shall be made in the following manner: (i) reimbursements made to acute hospitals shall be based on actual claims for health services provided to uninsured and underinsured patients that are submitted to the office, and shall be made only after determination that the claim is eligible for reimbursement pursuant to this chapter and any additional regulations promulgated by the office. Reimbursements for health services provided to residents of other states and foreign countries shall be prohibited, and the office shall make payments to acute hospitals using fee-for-service rates calculated as provided in paragraphs (iv) and (v); (ii) the office shall, in consultation with the office of Medicaid, develop and implement

procedures to verify the eligibility of individuals for whom health services are billed to the fund and to ensure that other coverage options are used fully before services are billed to the fund, including procedures adopted pursuant to section 36. The office shall review all claims billed to the fund to determine whether the patient is eligible for medical assistance pursuant to the provisions of this chapter and whether any third party is financially responsible for the costs of care provided to the patient. In making these determinations, the office shall verify the insurance status of each individual for whom a claim is made using all sources of data available to the office. The office shall refuse to allow payments or shall disallow payments to acute hospitals and community health centers for free care provided to individuals if reimbursement is available from other public or private sources; provided, however, that payments shall not be denied from the fund because services should have been provided in a more appropriate setting if the hospital was required to provide these services pursuant to 42 U.S.C. 1395(dd); (iii) the office shall require acute hospitals and community health centers to screen each applicant for reimbursed care for other sources of coverage and for potential eligibility for government programs, and to document the results of that screening. If an acute hospital or community health center determines that an applicant is potentially eligible for Medicaid or for the commonwealth care health insurance program, established pursuant to chapter 118H, or another assistance program, the acute hospital or community health center shall assist the applicant in applying for benefits under that program. The office shall audit the accounts of acute hospitals and community health centers to determine compliance with this section and shall deny payments from the fund for any acute hospital or community health center that fails to document compliance with this section; (iv) for the purposes of paying community health centers for health services provided to uninsured individuals pursuant to this section, the office shall pay community health centers a base rate that shall be no less than the then-current Medicare Federally Qualified Health Center rate as required pursuant to 42 U.S.C. 13951 (a)(3), and the office shall add payments for additional services not included in the base rate, including, but not limited to, EPSDT services, 340B pharmacy, urgent care, and emergency room diversion services; (vi) reimbursements to acute hospitals and community health centers for bad debt shall be made upon submission of evidence, in a form to be determined by the office, that reasonable efforts to collect the debt have been made; (v) the office shall reimburse acute hospitals for health services provided to individuals based on the payment systems in effect for acute hospitals used by the United States Department of Health and Human Services Centers for Medicare & Medicaid Services to administer the Medicare Program pursuant to Title XVIII of the Social Security Act, including all of Medicare's adjustments for direct and indirect graduate medical education, disproportionate share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of the annual increase in the Medicare hospital market basket index. The office shall, in consultation with the office of Medicaid and the Massachusetts Hospital Association, promulgate regulations necessary to modify these payment systems to account for: (a) the differences between the program administered by the office and the Title XVIII Medicare program, including the services and benefits covered; (b) grouper and DRG relative weights for purposes of calculating the payment rates to reimburse acute hospitals at rates no less than the rates they are reimbursed by Medicare; (c) the extent and duration of covered services; (d) the populations served; and (e) any other

adjustments to the payment methodology pursuant to this section as considered necessary by the office, based upon circumstances of individual hospitals.

Following implementation of this section, the office shall ensure that the allowable reimbursement rates pursuant to this section for health services provided to uninsured individuals shall not thereafter be less than rates of payment for comparable services pursuant to the Medicare program, taking into account the adjustments required by this section.

(b) By April 1 of the year preceding the start of the fund fiscal year, the office shall, after consultation with the office of Medicaid, and using the best data available, provide an estimate of the projected total reimbursable health services provided by acute hospitals and community health centers and emergency bad debt costs, the total funding available, and any projected shortfall after adjusting for reimbursement payments to community health centers. If a shortfall in revenue exists in any fund fiscal year to cover projected costs for reimbursement of health services, the office shall allocate that shortfall in a manner that reflects each hospital's proportional financial requirement for reimbursements from the fund, including, but not limited to, the establishment of a graduated reimbursement system and pursuant to any additional regulations promulgated by the office.

(c) The executive office of health and human services directly or through the division shall enter into interagency agreements with the department of revenue to verify income data for patients whose health care services are reimbursed by the Health Safety Net Trust Fund and to recover payments made by the fund for services provided to individuals who are ineligible to receive reimbursable health services or on whose behalf the fund has paid for emergency bad debt. The division shall promulgate regulations requiring acute hospitals to submit data that will enable the department of revenue to pursue recoveries from individuals who are ineligible for reimbursed health services and on whose behalf the fund has made payments to acute hospitals for emergency bad debt. Any amounts recovered shall be deposited in the Health Safety Net Trust Fund, established pursuant to section 36.

(d) The office shall not at any time make payments from the fund for any period in excess of amounts that have been paid into or are available in the fund for that period, but the office may temporarily prorate payments from the fund for cash flow purposes.

SECTION 14. Chapter 159B of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out section 10, as so appearing, and inserting in place thereof the following section:-

Section 10. Each interstate carrier by motor vehicle transporting over the ways within the commonwealth for compensation shall register and identify with the department pursuant to the federal Unified Carrier Registration Act of 2005. Each registration shall be accompanied by a fee, the amount of which shall be determined by the board of directors of the federal Unified Carrier Registration Plan.

SECTION 15. Section 4 of chapter 161B of the General Laws, as so appearing, is hereby amended by striking, in line 6, the following words: “fourteen; and” and inserting in place thereof the following:- fourteen; provided, further, that the appointment of said administrator shall be subject to the approval of the secretary and the secretary shall not approve any candidate who does not possess senior level management experience in 1 or more of the following areas: engineering, construction, business, public transit, public or private finance, or transportation; provided, further that the secretary may remove the administrator for just cause; and

SECTION 16. Section 8 of said Chapter 161B of the General Laws, as so appearing, is hereby amended by striking subsection (h) and inserting in place thereof the following new section:-

(h) All current expenses of the authority shall be in accordance with an annual budget prepared by the administrator and submitted to the advisory board, the secretary, the secretary of administration and finance, the chairs of the joint committee on transportation, and the chairs of the house and senate committees on ways and means no later than February first of each year for the ensuing fiscal year. On or before June first the advisory board shall approve said budget as submitted or subject it to such itemized reductions therein as the advisory board shall deem appropriate. After the advisory board has approved said budget the secretary of transportation shall approve said budget as submitted or shall subject it to such itemized reductions as he shall deem appropriate. An administrator must receive approval from the secretary for any additional costs after the budget has been approved by the advisory board.

SECTION 17. Sections 2 and 7 of chapter 772 of the acts of 1987 are hereby repealed.

SECTION 18. Section 7A of chapter 177 of the acts of 2001, as amended by section 13 of chapter 364 of the acts of 2002, is hereby repealed.

SECTION 19. Section 80 of chapter 177 of the acts of 2001, as amended by section 13 of chapter 364 of the acts of 2002, is hereby repealed.

SECTION 20. The first sentence of section 9 of chapter 61 of the acts of 2002 is hereby amended by striking out the figure "2007" and inserting in place thereof the following figure:- 2008.

SECTION 21. Chapter 58 of the acts of 2006 is hereby amended by striking out section 128 and inserting in place thereof the following section:

Section 128. Notwithstanding any general or special law to the contrary except for section 13B of chapter 118E of the General Laws, in fiscal year 2007 $90,000,000 shall be made available from the Commonwealth Care Trust Fund, established pursuant to section 2OOO of chapter 29 of the General Laws, to pay for an increase in the Medicaid rates paid to acute hospitals, as defined in section 1 of chapter 118G of the General Laws, and physicians, provided that not less than 15 per cent of the increase be allocated to rate

increases for physicians; provided further, that in fiscal year 2008, an additional $90,000,000, for a total of $180,000,000, shall be made available to pay for an increase in the Medicaid rates paid to acute hospitals, as defined in section 1 of chapter 118G of the General Laws, and physicians, provided that not less than 15 per cent of the increase be allocated to rate increases for physicians; and provided further, that in fiscal year 2009, an additional $90,000,000, for a total of $270,000,000, shall be made available to pay for an increase in the Medicaid rates paid to acute hospitals, as defined in said section 1 of said chapter 118G, and physicians, provided that not less than 15 per cent of the increase be allocated to rate increases for physicians. A portion of the fiscal year 2008 and fiscal year 2009 hospital rate increases relating to adherence to quality standards and achievement of performance benchmarks pursuant to section 13B of chapter 118E of the General Laws may be paid in the succeeding fiscal year. For purposes of payments to hospitals pursuant to this section, fiscal year shall mean the hospital fiscal year, and for purposes of any payments to physicians pursuant to this section, fiscal year shall mean the state fiscal year. Fiscal year 2008 and 2009 payments are subject to specific appropriation to the executive office of health and human services MassHealth program accounts for this purpose.

SECTION 22. Notwithstanding any general or special law to the contrary, the comptroller, in consultation with the secretary of health and human services, shall develop a schedule for transferring not less than $28,000,000 from the General Fund to the Essential Community Provider Trust Fund established pursuant to section 2PPP of chapter 29 of the General Laws for the purpose of making payments to hospitals and community health centers in fiscal year 2008. The secretary shall authorize expenditures from the fund without further appropriation for the purpose of a grant program to improve and enhance the ability of hospitals and community health centers to serve populations in need, more efficiently and effectively, including, but not limited to, the ability to provide community-based care, clinical support, care coordination services, disease management services, primary care services and pharmacy management services through a grant program. The office shall consider applications from acute hospitals, non-acute hospitals, and community health centers in awarding the grants; provided, however, that the office shall publicize the existence of the grant program to eligible providers and shall award grants no later than September 1, 2007. The criteria for selection shall include, but not be limited to, the following: (i) financial performance measures including negative operating margins, insufficient cash flow, technical bond default and the uncertain ability to cover long-term obligations, as well as potential for loss of critical community services; (ii) the percentage of patients with mental or substance abuse disorders served by a provider; (iii) the numbers of patients served by a provider who are chronically ill, elderly, or disabled, provided that in the case of a community health center, that preference be given to the provision of a Program of All-Inclusive Care for the Elderly; (iv) the payer mix of the provider, with preference given to acute hospitals where a minimum of 63 per cent of the acute hospital’s gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act or other governmental payors, including reimbursements from the Health Safety Net Trust Fund; (v) the percentage of total annual operating revenue that received funding in fiscal years

2005 and 2006 from the Distressed Provider Expendable Trust Fund comprised for the provider; (vi) the percentage of total annual operating revenue that received funding in fiscal year 2007 from the Essential Community Provided Trust Fund established pursuant to section 36 of chapter 118G of the General Laws; (vii) the cultural and linguistic challenges presented by the populations served by the provider; (viii) a documented critical need for investment in information technology such as Computerized Physician Order Entry systems but without access to capital to finance such investments; and (ix) the provision by a community health center of 24 hour emergency services.

The secretary may further authorize distributions on an emergency basis to acute hospitals, non-acute hospitals and community health centers facing extreme financial distress or closure upon petition from the provider. The emergency funds shall be distributed by the secretary within 2 weeks of petition by a provider that is determined to be facing extreme financial distress or closure at an amount determined by the secretary.

SECTION 23. Notwithstanding any general or special law to the contrary, the comptroller shall, in consultation with the state treasurer, the secretary of administration and finance and the secretary of health and human services, develop a schedule for transferring funds among the General Fund, the Commonwealth Care Trust Fund established pursuant to section 2OOO of chapter 29 of the General Laws and the Health Safety Net Trust Fund established pursuant to section 36 of chapter 118G of the General Laws. Not less than $628,800,000 shall be transferred from the General Fund to the Commonwealth Care Trust Fund and not less than $33,900,000 shall be transferred from the Commonwealth Care Trust Fund to the Health Safety Net Trust Fund; provided further, that the executive office of health and human services shall make expenditures required for fiscal year 2008 pursuant to section 122 of chapter 58 of the acts of 2006. The schedule shall provide for transfers in increments considered appropriate to meet the cash flow needs of these funds. The transfers shall not begin before July 1, 2007 and shall be completed on or before June 30, 2008. The secretary of administration and finance, in consultation with the secretary of health and human services and the executive director of the commonwealth health insurance connector, shall on a quarterly basis evaluate the revenue needs of the health safety net program funded by the Health Safety Net Trust Fund and the Commonwealth Care subsidized health insurance program funded from the Commonwealth Care Trust Fund, and if necessary, transfer monies between these funds for the purpose of ensuring that sufficient revenues are available to support projected program expenditures. The secretary of health and human services in consultation with the secretary of administration and finance and the executive director of the commonwealth health insurance connector shall submit a quarterly report to the house and senate committees on ways and means and joint committee on healthcare financing which shall include, but not be limited to, the projected and actual expenditures and revenues for the Commonwealth Care Trust Fund and any transfers made between the Health Safety Net Trust Fund and the Commonwealth Care Trust Fund.

Notwithstanding any general or special law to the contrary, on or before October 1, 2007 and without further appropriation, the comptroller shall transfer from the General

Fund to the Health Safety Net Trust Fund established pursuant to section 36 of chapter 118G of the General Laws, an amount not to exceed $45,000,000 for the purpose of making initial gross payments to qualifying acute care hospitals and community health centers for the hospital fiscal year beginning October 1, 2007. These payments shall be made to hospitals before, and in anticipation of, the payment by hospitals of their gross liability to this fund. The comptroller shall transfer from this fund to the General Fund not later than June 30, 2008, the amount of the transfer authorized in this section and any allocation of that amount as certified by the director of the health safety net office.

SECTION 24. Notwithstanding any general or special law to the contrary, the comptroller shall, in consultation with the office of the state treasurer, the executive office for administration and finance, and the executive office of health and human services, develop a schedule and make a series of transfers not to exceed $251,000,000 from the General Fund to the MassHealth provider payment account in the Medical Assistance Trust Fund established pursuant to section 2QQQ of chapter 29 of the General Laws.

SECTION 25. Notwithstanding any general or special law to the contrary, not less than 10 days after the effective date of this act, the comptroller shall transfer $10,000,000 from the General Fund to the Massachusetts Cultural Facilities Fund established pursuant to section 42 of chapter 23G of the General Laws.

SECTION 26. Notwithstanding any general or special law to the contrary, the comptroller shall, according to a schedule developed in consultation with the state treasurer and the secretary of administration and finance, transfer $345,053,006 from the General Fund to the State Retiree Benefits Trust Fund established pursuant to section 24 of chapter 32A of the General Laws.

SECTION 27. Notwithstanding any general or special law to the contrary, the comptroller shall, no later than June 30, 2008, transfer $150,000,000 to the General Fund from the Commonwealth Stabilization Fund established pursuant to section 2H of chapter 29 of the General Laws.

SECTION 28. Notwithstanding any general or special law to the contrary, during fiscal year 2008 the comptroller shall not transfer 0.5 per cent of the total revenue from taxes in the preceding fiscal year to the Commonwealth Stabilization Fund as otherwise required pursuant to clause (a) of section 5C of chapter 29 of the General Laws.

SECTION 29. Notwithstanding any general or special law to the contrary, the comptroller shall, no later than June 30, 2008, transfer from the Commonwealth Stabilization Fund to the General Fund the lesser of: (1) the interest paid on the Commonwealth Stabilization Fund during fiscal year 2008, or (2) $75,000,000.

SECTION 30. Notwithstanding any general or special law to the contrary, the comptroller shall not less than 10 days after the effective date of this act, transfer

$150,000,000 to the General Fund from the Health Care Security Trust Fund established pursuant to section 1 of chapter 29D of the General Laws.

SECTION 31. Notwithstanding any general or special law to the contrary, no later than June 30, 2008 the comptroller shall transfer the balance in the Health Care Quality Improvement Trust Fund established pursuant to section 2EEE of chapter 29 of the General Laws, to the General Fund.

SECTION 32. Notwithstanding any general or special law to the contrary, during fiscal year 2008, the comptroller shall transfer from the Health Care Security Trust established pursuant to chapter 29D of the General Laws to the General Fund an amount equal to 100 per cent of the total of all payments received by the commonwealth in fiscal year 2008 pursuant to the master settlement agreement in the action known as Commonwealth of Massachusetts v. Phillip Morris, Inc. et. al., Middlesex Superior Court, No. 95-7378 and 100 per cent of the earnings generated in fiscal year 2008 from the Health Care Security Trust as certified by the comptroller pursuant to paragraph (f) of section 3 of chapter 29D of the General Laws for certain health care expenditures appropriated in section 2 of this act.

SECTION 33. Notwithstanding any general or special law to the contrary, pension benefits authorized pursuant to chapters 712 and 721 of the acts of 1981, chapter 154 of the acts of 1983, chapter 67 of the acts of 1988, and chapter 621 of the acts of 1989, for the compensation of veterans who may be retired by the state board of retirement, including individuals formerly in the service of the division of employment security whose compensation for that service was paid in full from a grant from the federal government and for the cost of medical examinations in connection therewith, for pensions of retired judges or their widows or widowers, for retirement allowances of certain employees formerly in the service of the administrative division of the metropolitan district commission, for retirement allowances of certain veterans and police officers formerly in the service of the metropolitan district commission, for retirement allowances of certain veterans formerly in the service of the metropolitan sewerage district, for retirement allowances of certain veterans formerly in the service of the metropolitan water system and for annuities for widows or widowers of certain former members of the uniformed branch of the state police shall be funded from the Pension Reserves Investment Trust Fund, established pursuant to subdivision (8) of section 22 of chapter 32 of the General Laws. This section shall continue in effect after June 30, 2008.

SECTION 34. Notwithstanding any general or special law to the contrary, the amounts transferred pursuant to paragraph (1) of section 22C of chapter 32 of the General Laws shall be made available for the commonwealth's Pension Liability Fund established pursuant to section 22 of said chapter 32. The amounts transferred pursuant to said paragraph (1) of said section 22C of said chapter 32 shall meet the commonwealth's obligations pursuant to said section 22C of said chapter 32, including retirement benefits payable by the state employees' and the state teachers' retirement systems, for the costs associated with a 3 per cent cost-of-living adjustment pursuant to section 102 of said chapter 32, the reimbursement of local retirement systems for previously authorized cost-

of-living adjustments pursuant to said section 102 of said chapter 32, and for the costs of increased survivor benefits pursuant to chapter 389 of the acts of 1984. The state board of retirement and each city, town, county and district shall verify these costs, subject to the rules adopted by the treasurer. The treasurer may make payments upon a transfer of funds to reimburse certain cities and towns for pensions to retired teachers, including any other obligations which the commonwealth has assumed on behalf of any retirement system other than the state employees' or state teachers' retirement systems and also including the commonwealth's share of the amounts to be transferred pursuant to section 22B of said chapter 32 and the amounts to be transferred pursuant to clause (a) of the last paragraph of section 21 of chapter 138 of the General Laws. All payments for the purposes described in this section shall be made only pursuant to distribution of monies from the fund, and any distribution and the payments for which distributions are required shall be detailed in a written report filed quarterly by the commissioner of administration with the house and senate committees on ways and means and the joint committee on public service in advance of this distribution. Distributions shall not be made in advance of the date on which a payment is actually to be made. The state board of retirement may expend an amount for the purposes of the board of higher education's optional retirement program pursuant to section 40 of chapter 15A of the General Laws. To the extent that the amount transferred pursuant to paragraph (1) of section 22C of said chapter 32 exceeds the amount necessary to adequately fund the annual pension obligations, the excess amount shall be credited to the Pension Reserves Investment Trust Fund of the commonwealth for the purpose of reducing the unfunded pension liability of the commonwealth.

SECTION 35. Notwithstanding any general or special law to the contrary, in the event that any district attorney fails to comply with reporting language relevant to the use of drug forfeiture funds, so called, inserted in line items 0340-0100, 0340-0200, 0340-0300, 0340-0400, 0340-0500, 0340-0600, 0340-0700, 0340-0800, 0340-0900, 0340-1000, and 0340-1100 of section 2 of this act, the house and senate committees on ways and means shall notify the state comptroller of such failure to comply. A district attorney may request in writing a reasonable extension of the reporting period from the house and senate committees on ways and means. If such an extension is requested, the house and senate committees on ways and means shall not notify the state comptroller of a failure to comply with the reporting requirement until the extension period has elapsed. Upon receipt of said notification, the state comptroller shall make available to the witness protection board, established pursuant to section 2 of chapter 263A of the General Laws, the balance of said district attorney’s Special Law Enforcement Trust Fund, established pursuant to section 47 of chapter 94C of the General Laws, and any additional money transferred into said trust fund after the reporting date.

SECTION 36. (a) Notwithstanding any general or special law to the contrary, upon the request of the board of selectmen in a town, the city council in a plan E city or the mayor in any other city, the department of revenue may recalculate the minimum required local contribution, as defined in section 2 of chapter 70 of the General Laws, in the fiscal year ending June 30, 2008. Based on the criteria established in this section, the department

shall recalculate the minimum required local contribution for a municipality's local and regional schools and shall certify the amounts calculated to the department of education.

(b) A city or town that used qualifying revenue amounts in a fiscal year which will not be available for use in the next fiscal year, or that will be required to use revenues for extraordinary non school-related expenses for which it did not have to use revenues in the preceding fiscal year, or that has an excessive certified municipal revenue growth factor which is also greater than or equal to 1.5 times the state average municipal revenue growth factor, may appeal to the department of revenue not later than October 1, 2007 for an adjustment of its minimum required local contribution and net school spending.

(c) If a claim is determined to be valid, the department of revenue may reduce proportionately the minimum required local contribution amount based on the amount of shortfall in revenue or based on the amount of increase in extraordinary expenditures in the current fiscal year, but no adjustment to the minimum required local contribution on account of an extraordinary expense in the budget for the fiscal year ending on June 30, 2008 shall affect the calculation of the minimum required local contribution in subsequent fiscal years. Qualifying revenue amounts shall include, but not be limited to, extraordinary amounts of free cash, overlay surplus and other available funds.

(d) If, upon submission of adequate documentation, the department of revenue determines that the municipality's claim regarding an excessive municipal revenue growth factor is valid, the department shall recalculate the municipal revenue growth factor and the department of education shall use the revised growth factor to calculate the preliminary local contribution, the minimum required local contribution and any other factor that directly or indirectly uses the municipal revenue growth factor. Any relief granted as a result of an excessive municipal revenue growth factor shall be a permanent reduction in the minimum required local contribution.

(e) The board of selectmen in a town, the city council in a plan E city, the mayor in any other city, or a majority of the member municipalities of a regional school district, which used qualifying revenue amounts in a fiscal year that will not be available for use in the next fiscal year, may appeal to the department of revenue not later than October 1, 2007 for an adjustment to its net school spending requirement. If the claim is determined to be valid, the department of revenue shall reduce the net school spending requirement based on the amount of the shortfall in revenue and reduce the minimum required local contribution of member municipalities accordingly. Qualifying revenue amounts shall include, but not be limited to, extraordinary amounts of excess and deficiency, surplus and uncommitted reserves.

(f) If the regional school budget has already been adopted by two-thirds of the member municipalities then, upon a majority vote of the member municipalities, the regional school committee shall adjust the assessments of the member municipalities in accordance with the reduction in minimum required local contributions approved by the department of revenue or the department of education in accordance with this section.

(g) Notwithstanding clause (14) of section 3 of chapter 214 of the General Laws or any other general or special law to the contrary, the amounts so determined pursuant to this section shall be the minimum required local contribution described in chapter 70 of the General Laws. The department of revenue and the department of education shall notify the house and senate committees on ways and means and the joint committee on education of the amount of any reduction in the minimum required local contribution amount.

(h) If a city or town has an approved budget that exceeds the recalculated minimum required local contribution and net school spending amounts for its local school system or its recalculated minimum required local contribution to its regional school districts as provided by this section, the local appropriating authority shall determine the extent to which the community shall avail itself of any relief authorized pursuant to this section.

(i) The amount of financial assistance due from the commonwealth in fiscal year 2008 pursuant to chapter 70 of the General Laws or any other law shall not be changed on account of any redetermination of the minimum required local contribution pursuant to this section.

(j) The department of revenue and the department of education shall issue guidelines for their respective duties pursuant to this section.

SECTION 37. Notwithstanding any general or special law to the contrary, in order to maintain the fiscal viability of the subsidized catastrophic prescription drug insurance program, hereinafter referred to as the prescription advantage program, authorized by section 39 of chapter 19A of the General Laws, cost sharing required of enrollees in the form of co-payments, premiums and deductibles, or any combination thereof, may be adjusted by the department of elder affairs to reflect price trends for outpatient prescription drugs, as determined by the secretary of elder affairs. In addition to the eligibility requirements set forth in said section 39 of chapter 19A, to be considered eligible for the prescription advantage program, individuals who receive Medicare and are applying for, or are then enrolled in, the prescription advantage program shall also be enrolled in a Medicare prescription drug plan, a Medicare Advantage prescription drug plan, or in a plan which provides creditable prescription drug coverage as defined by section 104 of the Medicare Prescription Drug Improvement and Modernization Act of 2003, hereinafter referred to as MMA, and which provides coverage of the cost of prescription drugs actuarially equal to or better than that provided by Medicare Part D, hereinafter a creditable coverage plan.

In addition to the eligibility requirements set forth in said section 39 of chapter 19A, to be considered eligible for the prescription advantage program, individuals who receive Medicare and are applying for, or are then enrolled in, the prescription advantage program, who may qualify for the low-income subsidy, so-called, provided pursuant to the MMA Subpart P-Premiums and cost-sharing subsidies for low-income individuals, shall apply for those subsidies. To the extent permitted by MMA and regulations

promulgated thereunder, and all other applicable federal law, the prescription advantage program may apply on behalf of a member for enrollment into a Medicare prescription drug plan or for the low-income subsidy provided pursuant to MMA and may receive information about the member's eligibility and enrollment status necessary for the operation of the prescription advantage program.

For enrollees who qualify for enrollment in a Medicare Part D plan, the prescription advantage program will provide a supplemental source of financial assistance for prescription drug costs, hereinafter referred to as "supplemental assistance" in lieu of the catastrophic prescription drug coverage provided pursuant to said section 39 of chapter 19A. The prescription advantage program will provide supplemental assistance for premiums, deductibles, payments and co-payments required by a Medicare prescription drug plan or Medicare Advantage prescription drug plan, and will provide supplemental assistance for deductibles, payments and co-payments required by a creditable coverage plan. The department shall establish the amount of the supplemental assistance it will provide enrollees based on a sliding income scale and the coverage provided by the enrollees' Medicare prescription drug plan, Medicare Advantage prescription drug plan, or creditable coverage plan. In addition to the eligibility requirements set forth in section 39 of chapter 19A, to be considered eligible for the prescription advantage program, an individual must have a household income of less than 500 per cent of the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services pursuant to the authority of 42 U.S.C. 9902(2). Residents of the commonwealth who are not eligible for Medicare will continue to be eligible for the prescription advantage program pursuant to said section 39 of chapter 19A.

SECTION 38. Notwithstanding any general or special law to the contrary, the executive office of health and human services may, pursuant to section 16 of chapter 6A of the General Laws, acting in its capacity as the single state agency pursuant to Title XIX of the Social Security Act and as the principal agency for all of the agencies within the executive office and other federally assisted programs administered by the executive office, enter into interdepartmental services agreements with the University of Massachusetts Medical School to perform activities that the secretary, in consultation with the comptroller, determines are appropriate and within the scope of the proper administration of Title XIX and other federal funding provisions to support the programs and activities of the executive office. These activities shall include: (1) providing administrative services, including, but not limited to, activities such as providing the medical expertise to support or administer utilization management activities, determining eligibility based on disability, supporting case management activities and similar initiatives; (2) providing consulting services related to quality assurance, program evaluation and development, integrity and soundness and project management; and (3) providing activities and services for the purpose of pursuing federal reimbursement or avoiding costs, third party liability and recouping payments to third parties. Federal reimbursement for any expenditures made by the University of Massachusetts Medical School relative to federally reimbursable services the university provides under these interdepartmental service agreements or other contracts with the executive office of health and human services shall be distributed to the university, and recorded distinctly in

the state accounting system. The executive office of health and human services may negotiate contingency fees for activities and services related to the purpose of pursuing federal reimbursement or avoiding costs, and the comptroller shall certify these fees and pay them upon the receipt of this revenue, reimbursement or demonstration of costs avoided. Contracts for contingency fees shall not extend longer than 3 years, and shall not be renewed without prior review and approval from the executive office of administration and finance. The executive office of health and human services shall not pay contingency fees in excess of $40,000,000 for state fiscal year 2008. The secretary of the executive office of health and human services shall submit to the secretary of administration and finance and the senate and house committees on ways and means a quarterly report detailing the amounts of the agreements, the ongoing and new projects undertaken by the university, the amounts spent on personnel and the amount of federal reimbursement and recoupment payments that the university collected.

SECTION 39. Notwithstanding paragraph (a) of subsection (xxiii) of section 9 of chapter 211B of the General Laws, or any other general or special law to the contrary, the chief justice for administration and management may, from the effective date of this act through April 30, 2008, transfer funds from any item of appropriation within 1 of the 7 departments of the trial court to any other item of appropriation of the 7 departments. These transfers shall be made in accordance with schedules submitted to the house and senate committees on ways and means. The schedule shall include the following: (1) the amount of money transferred from 1 item of appropriation to another; (2) the reason for the necessity of the transfer; and (3) the date on which the transfer is to be completed. No transfer under this section shall occur until 10 days after the revised funding schedules have been submitted in written form to the house and senate committees on ways and means.

SECTION 40. Notwithstanding any general or special law to the contrary, in hospital fiscal year 2008, the office of the inspector general may continue to expend funds appropriated pursuant to section 1 of chapter 240 of the acts of 2004 for the costs associated with maintaining a pool audit unit within said office. The unit shall continue to oversee and examine the practices in all Massachusetts' hospitals including, but not limited to, the care of the uninsured and the resulting free care charges. The inspector general shall submit a report to the house and senate committees on ways and means on the results of the audits and any other completed analyses not later than March 1, 2008. For the purposes of said audits, allowable free care services shall be defined pursuant to chapter 118G of the General Laws and any regulations promulgated pursuant thereto.

SECTION 41. Notwithstanding any general or special law to the contrary, the executive office of transportation shall withhold and not expend 50 per cent of the amount appropriated to regional transit authorities pursuant to section 2 of this act until the secretary has certified that the authorities have satisfied all the reporting requirements of said section 2 and of chapter 161B of the General Laws; provided further, that the secretary shall hold said 50 per cent of the amount appropriated to regional transit authorities pursuant to said section 2 in a reserve account and shall only authorize the

expenditure of said 50 per cent of the amount appropriated to regional transit authorities pursuant to said section 2 upon certification by the secretary that the authorities have satisfied all the reporting requirements of said section 2 and of chapter 161B of the General Laws.

SECTION 42. Notwithstanding any general or special law to the contrary, the secretary of the executive office of administration and finance shall investigate ways to reduce administrative costs related to providing notice via first class mail to any person entitled to receive such notice pursuant to any general or special law. In conducting said investigation, the secretary shall consider the potential financial benefit to the commonwealth of allowing electronic notification in lieu of requiring notice only via first class mail and shall also consider alternative ways of notifying persons entitled to receive such notice pursuant to any general or special law who lack access to electronic communications equipment. The secretary shall report his findings and recommendations, including any proposed legislation, to the clerk of the senate, the clerk of the house of representatives and to the chairs of the house and senate committees on ways and means no later than December 31, 2007.

SECTION 43. Notwithstanding any general or special law to the contrary, there shall be a special commission to investigate and study the commonwealth's liability for paying retiree health care and other non-pension benefits. The commission shall specifically examine further legislation necessary to comply with statement number 43 and statement number 45 of the Government Accounting Standards Board, so-called, a possible amortization schedule to fund the commonwealth's liability, and the possibility of state borrowing against future tobacco litigation proceeds to fund the commonwealth's liability for said retiree health care and other non-pension benefits. The commission shall consist of the chairs of the joint committee on public service, who shall co-chair the commission, the chairs of the house and senate committees on ways and means, the secretary of administration and finance, or his designee, the state treasurer, or his designee, the state comptroller, or his designee, the executive director of the pension reserves investment management board, or his designee, and the executive director of the group insurance commission, or his designee. The commission shall report its findings and recommendations, including any proposed legislation, to the clerk of the senate, to the clerk of the house of representatives and to the chairs of the house and senate committees on ways and means not later than December 31, 2007.

SECTION 44. Sections 4 and 18 of this act shall take effect June 30, 2007.

SECTION 45. Section 12 of this act shall take effect October 1, 2007.

SECTION 46. Except as otherwise provided, this act shall take effect on July 1, 2007.